NASMHPD Medical Directors Council
9th Technical Paper

State Mental Health Authorities' Response to Terrorism

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Chapter One

I. INTRODUCTION

NASMHPD's Medical Directors Council developed its ninth technical paper through a series of pre-meeting conferences calls and extensive discussions at a workgroup summit held May 5-6, 2003 in Alexandria, Virginia. Participants included State Mental Health Authority (SMHA) medical directors, commissioners, public health leaders, consumers, disaster mental health experts and consultants with Federal and State response experience. A complete list of participants is included as Attachment A.

The Council recognized that Americans want to learn more about terrorism and, particularly, how they can feel safe. Through state emergency planning and response functions, SMHAs have the recognized lead role in responding to the psychosocial consequences of terrorist acts which requires understanding and planning for the consequences of terrorism. The 1995 Oklahoma City bombing and the terrorist acts of September 11, 2001 continue to be studied, providing clinical information, some outcome data and emerging best practices. With this in mind, the Medical Directors Council created this publication to serve as a (1) a clinical guide, (2) a policy/planning stimulant and (3) as a general information resource for the SMHA Commissioner or Medical Director who must be rapidly briefed before responding to a critical event.

SMHA lessons learned from recent terrorist events will be shared in text boxes throughout the document. Resource tips will also be featured.

Much of the Council's discussion centered on a public health approach to terrorism, recognizing that terrorism affects the overall health and psychological framework of the affected population. This approach expands the SMHA client base from traditional consumers with serious and persistent mental illness (SMI) and those who are seriously emotionally disturbed (SED) to the general population of the agency's service area(s). Given this broader mission, SMHA preparedness is essential.

This Council reviewed current literature, examined their own experiences as well as best practices and agreed upon these basic tenets:

- The goal of terrorism is to inflict psychological injury; physical injury is the delivery method. The expected ratio of behavioral to physical casualties is 4:1.
- State Mental Health Authority leaders must prepare for terrorism and commit to following an all-hazards approach to emergency and disaster planning.
- In its lead role in managing a bioevent, Public Health is at the frontline of terrorism response involving weapons of mass destruction (WMD). Mental Health must partner with Public Health throughout the preparedness, surveillance, response and recovery continuum.
- Pre-existing relationships are critical in disaster response and recovery. SMHAs should work in advance with Public Health, public and private disaster response agencies, sister state agencies and non-traditional partners which are addressed in Chapter II of this document. These existing relationships often determine the effectiveness of the SMHA role in the days following an event.

- During the current period of severe decline in State resources, a significant challenge to effective SMHA terrorism preparedness and response is the expansion of (1) the mental health mission and (2) the population served.
- There is an emerging body of guidelines and best practices although more research is needed.

This paper is divided into three chapters. Chapter I describes the impacts of a terrorist act followed by a review of key issues pertaining to special populations. All-hazards planning and crisis communication are addressed briefly. Chapter II details the workgroup's recommendations to SMHA Commissioners, Medical Directors and NASMHPD. Chapter III provides an overview of the key agencies and behavioral health programs involved in terrorism response. Citations are listed at the end of the document, followed by these attachments:

A. List of Meeting Participants (NASMHPD to provide)
B. References
C. Websites
D. Glossary of Terms
E. SMHA Disaster Management Checklist (being expanded by EMHTSSB/ESI)

II. UNDERSTANDING THE IMPACTS OF TERRORISM

The primary goal of terrorism is to inflict psychological injury. Physical injury is a byproduct of the delivery method, creating individual and group impairment as well as social and governmental disruption. Victims of mass violence caused by malicious human intent are far more likely than victims of other disasters to be severely impaired by the event. (Norris et al 2002, Fall, Part I) Research shows that when destruction, harm and death are intentional, they are particularly hard for survivors to make sense of.(Ibid.)

To assess the psychological impact within the first three months post 9/11, the Centers for Disease Control conducted random telephone surveys of 3512 persons in Connecticut, New Jersey and New York. The CDC found the short-term effects of the attacks included (Anonymous 2002 Sep 6):

- 75% had problems attributed to the attack
- 27% missed work
- 21% increased smoking and 1% started smoking
- 12% of respondents with problems sought help from either family members (36%) or friends/neighbors (31%)
- 3% increased drinking

Understanding the impacts of terror is critical to creating an all-hazards plan and developing an effective psychosocial response. An overview of key concepts follows.

A. Individual Responses to Traumatic Stress. Individual response to trauma is generally predictable and usually transient. While many individuals may benefit from assistance following trauma, the literature demonstrates that most individuals will adapt via a range of

positive coping responses which include the use of social supports, and their distress general resolves within three months. Only a small portion of trauma victims will eventually require therapy for pathological response. (Litz et al 2003) There are predictable phases individuals experience in response to large-scale traumatic events and weapons of mass destruction. This information has been gleaned from military and disaster psychiatry.(Lacy and Benedek 2003)

Phase 1: Immediate Response: Post-traumatic distress is common and should be expected in the weeks following a terrorist event. Distress response spans a range that include strong emotions, disbelief, numbness, fear, anxiety and confusion. Physical responses such as hyper arousal are not uncommon, particularly in the immediate aftermath of an attack. Initially, somatic responses include the release of stress hormones and peripheral catecholamines which usually result in improved cognitive performance. However, as time passes and the stress response persists, behavior and thinking may become narrowly focused with a loss of flexibility. Thinking may eventually become disorganized, resulting in either a fight or flight response or a freeze response. During this phase, the risk of mass panic or acute outbreaks of medically unexplained symptoms is at its peak. (Lacy and Benedek 2003)

An immediate, coordinated response to a terrorist event is critical. Mental health, public health and the medical community become first responders.

Phase 2: Intermediate Response: Adaptation, Arousal and Avoidance. Phase two of the traumatic response occurs from one week to several months after the event. Intrusive symptoms such as recollections of the event associated with hyper arousal, hypervigilance, insomnia and nightmares are common. Behavioral distress may present through increased visits to primary care providers where individuals may report new symptoms or worsening of existing health problems. Stress may even precipitate early labor in pregnant women or cause fetal distress. Emotional symptoms during this phase include, anger, irritability and apathy. Distress, grief, mourning, and other factors may contribute to social withdrawal. (Lacy and Benedek 2003) Individuals suffering from acute distress with dissociation may develop acute stress disorder during this phase. (Litz et al).

Phase 3: Long-term Response: Recovery, Impairment and Change. Phase three may last up to a year or more and may include post-trauma distress. In the year following the event, victims may experience feelings of disappointment and resentment especially if initial hopes for aid and restoration are not met. Historical community supports may have been disrupted and weakened by the event. Social assets may be further strained as they are redirected to address personal needs. A small number of individuals may experience continued posttraumatic distress including extended grief and mourning that may be classified as a psychiatric disorder for years after the attack. The majority of persons in the impacted community will rebuild their lives and focus on future challenges. (Lacy and Benedek 2003) Many will emerge from the event with strong, more adaptive coping skills as a result of their experience.

B. Community Impact and Social Loss. The collective nature of a terrorist event can be particularly distressing given the event's impact on the same social connections that can mitigate distress and support post-traumatic recovery. One disaster example comes from Kentucky flood victims who reflected an element of community destruction independent of self-reported personal loss. While changes based on this sense of loss did not represent psychopathology, they did suggest that disasters that harm the entire community's quality of life will manifest ongoing, though subclinical expressions of stress. (Norris et al 1994)

Research now coming out of lower Manhattan following the September 11 attacks on the World Trade Center also supports a broader, public health perspective regarding disaster effects (Galea et al 2002) Other studies of Manhattan residents following 9/11 found that individuals who suffered social loss had greater impairment than those with only individual psychological impacts. SMHAs must consider not only individual post-trauma interventions but interventions using community-based and community-centered approaches, recognizing the experience of pain not only as individual, but also as communal. (Vlahov 2002) Terrorism's ripple effects may hit hardest on neighborhoods already suffering economic distress, especially those with low income, immigrant populations. For example, the travel, hospitality and service industries experienced dramatic and sustained downturns following 9/11. These employment sectors disproportionately attract immigrants and low-wage earners who continue to face both political and economic impacts of 9/11 as well as diminished philanthropic support in their neighborhoods. Safety net programs essential to the community's health and social fabric struggle post 9/11 as do the residents themselves.

C. Common Reactions and Syndromes. In the wake of terrorism, most people will experience some level of psychological distress, including an altered sense of safety and a range of physical, emotional and behavioral distress responses. (Hall et al 2003) Researchers studying the outcomes of 9/11 found that psychological effects were not limited to those who experienced the trauma directly; trauma distress following 9/11 was evidenced nationwide. (Silver et al 2002)

Chemical, biological, radiological, nuclear and high-yield explosive (CBRNE) weapons are especially effective at causing terror. (Holloway et al 1997) Biological agents, invisible, odorless and often imperceptible to humans, and agents with delayed and protracted symptoms are particularly terrorizing to potentially exposed individuals. Because symptoms of exposure are ubiquitous and often difficult to assess, victims have a heightened sense of vulnerability, loss of control and anxiety (Hall et al 2003)

There are longer term impacts/ consequences of terror vs. natural disasters. Anticipate the need for and seek funding of mental health programs and services for approximately 3-5 years post-event.

1) **Panic.** The commonly held assumption that mass panic automatically follows a terrorist event is unfounded. Panic refers primarily to a group phenomenon in which intense, contagious fear causes people to think only of themselves. Contrary to popular belief,

panic rarely occurs following disasters.(Lacy and Benedek 2003) [1] Research shows that following the initial impact, 12-25% of the population are able to analyze the dangers, formulate a plan and act on it while 75% are stunned and the remaining 10-25% become confused, perhaps paralyzed by fear or anxiety, or hysterical. (Tyhurst 1951) Risk factors for panic include (Glass and Schoch-Spana 2002):

- the belief that there is a small chance of escape
- seeing oneself as being at high risk of becoming ill
- available, but limited, resources in which the concept "first come, first served" prevails
- a perceived lack of effective management of the catastrophe
- loss of credibility by authorities

2) **Acute Stress Disorder** is an anxiety disorder that develops within two to four weeks of the traumatic event or experience. Diagnostic criteria are met when an individual experiences significant distress, including re-experiencing, avoidance and increased arousal as well as dissociation symptoms, such as numbing, reduced awareness of surroundings, derealization, depersonalization and dissociative amnesia. (Litz et al 2003) While age and gender have not been shown to be predictive factors of ASD, they are factors that should be considered in designing the intervention. A relatively new diagnosis, ASD may serve to identify individuals who are at most risk of developing PTSD.(Ibid)

3) **PTSD** Post-Traumatic Stress Disorder is the "common cold" of mental health response to a traumatic event.[2] Although the risk of experiencing a traumatic event is high (60%-90%) (Breslau et al 1998, Kessler et al 1995), the prevalence of PTSD is low, with estimates of 8%-9% of individuals exposed to trauma reporting PTSD at some point in their lifetime. (Kessler et al 1995) Just as a common cold may precede pneumonia, PTSD often may resolve without intervention or develop into something more serious. Untreated, it may result in a debilitating condition that continues for many years. Individuals with PTSD have persistent frightening thoughts and memories of their ordeal and feel emotionally numb. Some people with PTSD repeatedly relive the trauma in the form of nightmares and disturbing recollections during the day. They also may experience sleep problems and depression. Behavioral distress may present at irritability, increased aggression, or even violence. Visual reminders of the incident may be very distressing, leading to avoidance of certain places or situations that trigger memories of the event. Anniversaries of the event often are difficult and may trigger distress years later. Despite therapeutic intervention, a core group of individuals with PTSD (estimated as high as 30%) may fail to recover after many years.(NCPTSD)

[1] As of this writing, the most recent accounts of panic behavior occurred in China following the severe acute respiratory syndrome (SARS) outbreak in early 2003. Accounts published in the popular press indicated the behavior was driven by government misinformation, distrust and unmitigated fear.

[2] Urasano, R., Department of Psychiatry, Uniformed Services University in Bethesda, MD. Personal communication with editors and meeting participants.

4) **Depression** is a common consequence of disaster and terrorism. Sadness and depressed mood follows loss, whether the loss is a loved one, property or, as in terrorism, a sense of safety. Following 9/11, many individuals experienced depressed mood, decreased appetite and trouble sleeping. These are all associated with depression. Most depressive episodes, including those following disaster and terrorism, are self-limiting. The symptoms resolve without mental health intervention. Some post-trauma depression becomes more severe and requires therapeutic intervention.

5) **Generalized Anxiety Disorder (GAD)** Distress and anxiety are common reactions to trauma. Persons who experience frightening events become anxious and worry about other bad things that might happen. If these symptoms persist for more than six months and they cause significant distress, which may include physical symptoms, and impair functioning, criteria are met to establish a diagnosis of Generalized Anxiety Disorder. Mental health intervention should be considered and medications may be helpful**.**

6) **Medically Unexplained Physical Symptoms (MUPS).** Post-traumatic distress symptoms such as hyper arousal and intense anxiety can cause multiple, somatic symptoms such as heart racing, shortness of breath, flushing and nausea. Virtually any organ system may be involved. Acutely traumatized, frightened individuals may easily attribute these physical sensations to CBRNE[3] agents.(Lacy and Benedek 2003) The largely unknown nature surrounding exposure to CBRNE agents—uncertainty regarding whether exposure occurred, evolving treatment interventions and uncertainty regarding long-term outcomes—make the exposure—real or perceived—a particularly terrifying and anxiety producing event. (Holloway et al 1997) This first MUPS cases emerged after World War I as "shell-shocked" victims returned home. Similar symptomatology was evidenced by soldiers fearful of exposure to Agent Orange in Vietnam. The post-traumatic presentation of unexplained physical symptoms was labeled Gulf War Syndrome in the 1990s as hundreds of U.S. soldiers returned from the Middle East with a range of physical complaints including headaches, numbness, joint pain and gastrointestinal distress. Physical complaints were often accompanied by sleeplessness and anxiety, heightened by evidence that the source of the distress was largely unexplained. Similarly, victims of anthrax exposure at the Washington Postal Processing and Distribution Center, Brentwood, experienced a range of somatic complaints that persisted months, and for some, more than a year after the event. The military took an active approach in screening for physical symptomatology as well as traditional psychiatric problems post 9/11 at the Pentagon.(Hoge et al 2002) Lessons learned in the Gulf War experience triggered a proactive response to the call up for the 2003 War in Iraq. According to the popular press, soldiers were screened via a battery of tests, intended to provide baseline values against which to assess physical and behavioral status upon their return.

7) Psychiatric Aspects of Biological Agents. Nerve agents such as sarin, tabun, sonan and VX have the greatest potential among chemical weapons for causing confusion in diagnosis. The effects of nerve agents include intellectual impairment, anxiety,

[3] Acronym for chemical, biological, radiological, nuclear and high yield explosives.

psychomotor retardation and disturbed sleep patterns. Other known exposure effects include depressed mood, social withdrawal, insomnia with unpleasant dreams, and "anti-social thought." Of the drugs associated with the management of nerve agent exposure, atropine has the most potential for serious alterations in mental status. Most civilian physicians are accustomed to using atropine in low doses but treatment of patients exposed to acetylcholinesterase inhibitors may require much higher doses in the first 24 hours. Given in excess of the patient's needs, atropine can produce psychiatric side effects ranging from drowsiness to hyper activity, hallucinations and coma according to Headley, Longo and Wadia et al. Many biological weapons can cause delirium. (DiGiovanni 1999)

D. Service Needs

1) **Emergency Room Triage.** Emergency rooms can be overwhelmed by psychologically affected persons inappropriately seeking medical assistance**.** During the Scud Missile attacks on Israel during the 1991 Gulf War, only 22% of the more than 1,000 presenting for emergency care had been directly injured. (Karsenty et al 1991) Following the 1995 sarin gas attacks in a Tokyo subway, over 4,000 people who showed no signs of exposure sought emergency medical care. (Ohbu et al 1997) SMHAs must be prepared to support behavioral health interventions for the large numbers that may be expected to seek emergency care following a terrorist event.

Recommendations concerning early emergency care for psychologically distressed victims, include (Hall et al 2003):

- avoid use of the term "worried well"; victims may feel their concerns are not being taken seriously
- use non-stigmatizing labeling systems that assign risk as high, moderate and minimal
- co-locate treatment areas in the emergency room for patients who are not reassured by negative findings
- establish a clinical registry to follow up patients who are distressed.

Early interventions should be focused on well being, not mental health, with an emphasis on stress management, psychoeducation and limiting exposure to traumatic images. (Hall et al 2003)

2) Early Intervention. Historically, people and communities respond cooperatively and adaptively in most natural and manmade disasters. (Glass and Schoch-Spana 2002) The assumption that people will panic or behave irrationally following an event has negative consequences. Authorities may provide inaccurate information or unfounded reassurance motivated by a wish to calm the public. The panic myth may also lead response agencies to

Be aware of pre-existing trauma in the community. The 2002 sniper shootings in metro Washington, DC, were exceptionally terrorizing as they occurred after the one-year anniversary of 9/11 and the anthrax letters.

neglect the public's role in planning and response and miss opportunities to leverage a community's social capital in managing the response. (Hall et al 2002)

3) **Evidence-Based Interventions.** According to the National Institute of Mental Health, there is limited Level 1[4] evidence to definitively confirm or refute the effectiveness of any early psychological intervention following mass violence and disasters. The current evidence, often drawing on other types of traumatic events, permits the following conclusions (National Institute of Mental Health 2002):

    a. There is some Level I evidence:
        - for the effectiveness of early, brief, and focused psychotherapeutic intervention (provided on an individual or a group basis) for reducing distress in bereaved spouses, parents, and children.
        - that selected cognitive behavioral approaches may help reduce incidence, duration, and severity of ASD, PTSD, and depression in trauma survivors (e.g. victims of accidents, rape and crime).
        - suggesting that early intervention in the form of a single one-on-one recital of events and expression of emotions evoked by a traumatic event (as advocated in some forms of psychological debriefing) does not consistently reduce risks of later developing PTSD or related adjustment difficulties. Some survivors (e.g. those with high arousal) may be put at heightened risk for adverse outcomes as a result of such early interventions.
    b. There is no evidence that eye movement desensitization and reprocessing (EMDR) as an early mental health intervention following mass violence and disasters is a treatment of choice over other approaches.

4) **Projected Service Needs**. Research shows that transient post-traumatic distress may materialize in 20-50% of persons exposed to disasters. In a CBRNE event, that number is likely to be higher.

    Following 9/11, the Department of Defense launched Operation Solace to provide post-disaster recovery and support services to victims of the attack on the Pentagon. Project design reflected lessons learned from Oklahoma City and the military's experience with MUPS. Demand assessments for psychosocial support and psychological intervention for victims of the attacks at the two Federal facilities are compared with some caveats. (Hoge et al 2002) In Oklahoma City, the SMHA considered the entire population of the city while at the Pentagon, the response focused solely upon military employees and their families. Through their FEMA-funded Crisis Counseling Programs, the SMHAs in Virginia and Washington, DC, served the non-military populations impacted by 9/11. In comparing the following needs assessment figures, note that the Oklahoma figures lead to actual numbers served while the Pentagon information informed its ongoing response to estimate numbers to be served.

[4] The Agency for Health Care Policy and Research (AHCPR) has defined a system of classification for levels of evidence in scientific trials. In this document, Level 1 evidence, which is considered "the gold standard," refers to randomized, well-controlled clinical trials.

The April 19, 1995 bombing of the Murrah Building in Oklahoma City wounded 853 people and caused 168 deaths; the 9/11 attack on the Pentagon wounded 104 people and caused 125 deaths. Approximately 1,100 people were in the immediate blast area plus 16,000 Oklahomans worked or resided within 50 square blocks of the Murrah building. An estimated 4,500 people were in the Pentagon wedge with 24,000 total personnel working in the building. Oklahoma City has a population of 500,000; the military focused on the 400,000 persons who are National Capital Region beneficiaries under their health plan. In Oklahoma City during the first 2.5 years post-event, the actual number of clients served was 9,000 and their visits totaled 40,000. Based upon the Oklahoma experience, the Pentagon anticipates serving 13,500 clients via 54,000 visits.(Hoge et al 2002)

(Placeholder for information on Project Liberty needs assessment tool. Trading phone messages with April Naturale. Waiting to hear from Chip Belton)

Under Operation Solace, small multi-disciplinary teams of psychiatrists, psychologists, psychiatric nurses and social workers worked with chaplains to provide outreach within the Pentagon and surrounding offices. These pre-clinical visits became known among planners and providers as "therapy by walking around" since the teams engaged directly with workers in supportive ways in their own work environment. Clinical records were created only for employees who needed medication or more intense therapy. In addition, care managers (behavioral health professionals) were teamed with primary care providers to coordinate care with individuals serve persons referred to or seeking care in the health clinic. (Hoge et al 2002)

Within two months of the attack, the behavioral health professionals made nearly 40,000 contacts including 23,187 individual contacts, 10,599 group educational contacts and 5,709 contacts during debriefings. Lessons learned include (Hoge et al 2002):

- Avoid medicalizing initial reactions.
- Don't open medical records for initial care.
- Use "therapy by walking around" and triage those in need by work or social group.
- Partner mental health care managers with primary care doctors for victims/survivors seeking health care.
- People don't panic but want information. Crisis communication leaders need to be highly visible and provide small amounts of information frequently.
- Be sure to protect the trust and credibility of leadership/management.
- Pay attention to social connectedness. Provide small, meaningful tasks to increase group interaction and connectedness.

E. Longitudinal course. In a nationwide longitudinal study of the psychological responses to September 11, the national probability sample was comprised of 3496 adults. Of those, 2729 (78% participation rate) completed a web-based survey between nine to 23 days post attack. A random sample of 1069 panelists residing outside New York City received a second survey two months post-9/11 with 933 (87% participation rate) completing it. Six months after the attack, 787 completed a third survey. The following aggregate data demonstrate the longitudinal course of PTSD (Silver et al 2002, Anonymous 2002 Sep 6, Anonymous 2002 Sep 11):

Table 1. Longitudinal Course of PTSD

Symptom	2-3 weeks	2 months	6 months
Dissociative/avoidance	30%	30%	11%
Anxious	41%	30%	11%
Re-experience transient symptoms and smaller group with ongoing symptoms	54%	48%	23%
ASD or PTSD	12%	17%	6%

Clearly, post-disaster distress is most acute in the immediate period following the event and most individuals will recover.

F. Research. Disaster Mental Health is a specialized field and few mental health professionals are trained and experienced in its multi-dimensional approach. Although many clinicians are trained in trauma, even fewer are prepared to manage the range of responses to individual and communal post-disaster distress. SMHAs should support ongoing research in the field, particularly research on the outcomes of early intervention models and interventions which support psychosocial recovery over time

III. SPECIAL POPULATIONS

Many Americans feel a diminished sense of safety and security post 9/11. The horror of the 9/11 attacks has changed fundamental beliefs on the individual level and social norms at a community level. Elevated security threat warnings and military deployment are ongoing reminders that permeate the culture of impacted communities. While the vast majority of individuals will adapt to the new stressors and, over time, emerge with greater resiliency from the experience, there is a growing body of literature on individual-risk factors that include environmental characteristics, personal history and degree of association with the event.

> Media and public perceptions may create "non-relevant victims," i.e. those impacted by invisible chemical agents in scattered locations vs. those located in a dramatically damaged building. Ensure services to all.

A. General Risk Factors. Mass violence events/disasters have a greater psychological impact than those of natural disasters or technological events. The empirical review incorporated findings from 160 samples and 102 disasters worldwide. Identified risk factors are summarized in the following table from Norris' research based on a large analysis of disaster-victims' outcomes (Norris et al, 2002, Fall, Part II).

Table 2. Individual-Level Risk Factors for Poor Mental Health Outcome

Category	**Risk factor**
Trauma and stress	Severe exposure to the disaster, especially injury, threat to life and extreme loss. Living in the context of a neighborhood or community that is highly disrupted or

Category	Risk factor
	traumatized. High secondary stress, regardless of whether it is of an acute or chronic nature.
Survivor characteristics	Female gender If an adult survivor, age in the middle years of 40-60 Little previous experience relevant to coping with the disaster. Membership in an ethnic minority group. Poverty or low socioeconomic status. Predisaster psychiatric history.
Family context	If an adult survivor, the presence of children in the home and, if female, the presence of a spouse. If child survivor, the presence of parental distress. The presence of a family member who is significantly distressed. Interpersonal conflict or lack of supportive atmosphere in the home.
Resource context	Lacking or losing beliefs in one's ability to cope and control outcome. Possessing few, weak, or deteriorating resources.

B. Consumers of mental health services. Research shows that consumer' response to disasters and terrorism mirrors that of the general public. In most instances post-event, this population tends to stay closely connected and, in fact, hospital admissions decrease. Problems may occur later if the social fabric of the community is destroyed and community support is reduced or inaccessible. Self-help and peer-support groups are vital. SMHA all-hazards plans should address systems to assure consumer access to prescribed medications as well as communal support resources.

Clinicians should be cautioned that *stress* reactions in consumers can manifest in ways that mimic exacerbation of psychiatric illness (such as agitation, hyperarousal, sleep disturbance, etc.) Clinicians should evaluate whether anti-anxiety medications (if any) are needed to address such symptoms during the initial stages of an event and should also avoid "medicalizing" such typical stress responses**.**

To gauge the impact of 9/11 on mental health consumers, staff psychiatrists and mental health workers in the Missouri Department of Mental Health (DMH) conducted a six-question survey during the course of treating 11,052 patients between January-February 2002. The findings were not substantially different from what is known about the general population post-event.

- 50% of the clients felt nervous or worried

- 15% felt numb and avoid people
- 13% felt less able to cope
- 5% reported an increase in alcohol or drug use
- almost 6% and 14% felt the need for more substance abuse treatment and mental health treatment, respectively.

Of those in treatment or receiving DMH services, the group feeling the lowest impact were housed at a maximum security facility for forensics and persons not guilty by reason of insanity (NGRI). Persons obtaining substance abuse treatment services reported the need for both substance abuse and psychiatric services, with a slightly higher need for mental health services. The most highly impacted facility was a substance abuse treatment center specializing in traumatized women with PTSD. This finding is consistent with evidence from the literature that prior trauma history and prior psychological conditions are risk factors for recovery from a subsequent traumatic event (Norris et al, 2002, Fall, Part II).

C. Children. Children respond to a traumatic event according to their age, personality, personal history, developmental level, degree of exposure and the responses of adults close to them.

Below are important guidelines for parents and caregivers such as teachers, school counselors, pediatricians, Scout leaders, clergy and other adults involved with the child:

- The parents'/caretakers' response to the event will affect the child's response.
- Maintain the child's normal routine to the extent possible, especially at home and at school, to reduce stress.
- Children need information delivered to them at their developmental level and in words they can understand.
- Encourage children to talk about their feelings or to express them in other appropriate ways such as drawing or other art forms.
- Consider the child's age and developmental level regarding access to television coverage of the event.
- Changes in behavior and regression to earlier behaviors may indicate distress. Be trained on what to look for such as persistent fears related to the catastrophe, loss of concentration and irritability, and physical complaints (stomach aches, headaches, dizziness) for which there appears to be no physical cause.
- Age-specific stress reactions may exhibit as follows:
    - Pre-verbal children may sense that their parent(s) is anxious so the child becomes anxious.
    - Toddlers may regress, become more oppositional, angry, clingy, have sleep problems and nightmares.
    - Pre-schoolers may exhibit their views and fears through their play.
    - Grade school children and older children are more verbal. And, like teens, may exhibit changes in behavior, mood, sleep, eating, and relationships.
- Children, just like adults, may not exhibit any issues for six months or until anniversary periods.
- Be especially sensitive with children who directly witnessed trauma as, of course, they may be at higher risk of developing more significant psychosocial reactions.

For more detailed and age-specific guidance, review the list of websites in Attachment C of this document.

Children and Schools. When considering the needs of children, remember that the school environment is central to their lives and, frequently, to the lives of their families. Schools often have significant symbolic value in communities and are, in addition, the work place for both students and varied school staff. Understand that schools have their own special populations: children administered special medications or other therapeutic treatments, hearing impaired, physical and mentally challenged. For safety reasons, schools function as closed systems. They are required to have their own safety plans and traditionally have their own crisis teams to respond to critical incidents. During the Metropolitan Washington, D.C. sniper shootings in Fall 2002, leaders of the local mental health authorities in Maryland worked with schools, pediatricians, and clergy among others regarding how to work with children. The strong state level relationship between mental health and education filtered to the local mental health authorities and their corresponding school superintendent. Virginia and the District also worked with local community-based organizations to share information about how to support children affected by the terrorist event. The three jurisdictions common message was, "We're here if you need us."

> It is often difficult to link with schools as they are extremely protective of their students and teachers, and have legitimate concerns about the intervention of "outsiders" in times of crisis. Pre-event relationships are key.

D. Elderly. Research shows that being elderly is not a risk factor for psychological issues post-disaster as seniors often possess a life-long history of positive coping. (Norris 2002 Spring) Factors to consider in this group are diminished health status, poverty and social isolation. In planning for senior care, assure that special mediation and other health needs are met. Maintain social connections and re-establish prior coping skills and strategies as goals during recovery.

E. Hearing-impaired. State SMHAs must adequately address this population in their all-hazards plan and ensure appropriate materials, communication methods and interpreters. Warnings and event-notification are a concern, particularly for isolated individuals who lack electronic alert and messaging equipment. Ensure first responders are aware of this population in the SMHA service areas. In a nationwide survey of community mental health centers only one-third of the respondents addressed a plan for the hearing-impaired.

F. Substance abuse (SA). Studies on the impact of traumatic distress and substance use is limited and inconsistent. Research shows persons with pre-existing Post-Traumatic Stress Disorder (PTSD), trauma and co-occurring disorders are most at risk for developing substance abuse issues post-event. The literature presents a range of 30-60% of persons with substance use disorder who meet the criteria for PTSD with PTSD occurring first followed by the substance abuse. After 9/11, the New York Academy of Medicine administered a survey which found increased substance use, smoking and use of sleeping medications with some people abusing these substances. One explanation is the unprecedented exposure to the event with estimates of 1.2 million witnesses in NYC. In the CDC random telephone survey of persons within the first three months of the WTC attack, 21% of the 3512 respondents

increased smoking and 3% increased drinking.(Anonymous 2002 Sep 6) There was no longer term information from either study.

Although SMHAs coordinate both mental health and substance abuse services, many do not. Those who do not should collaborate with the agencies responsible to ensure coordinated and comprehensive services. There is a new mandate out of SAMHSA to deal with substance abuse issues as part of the mental health response to large-scale disasters. SMHA providers should be trained in basic SA screening tools and SA treatment options to aid in detecting increased substance use and ensure referral and triage as necessary. SAMHSA's Center for Substance Abuse Treatment (CSAT) will be issuing a treatment improvement protocol (TIP) specific to substance abuse and disasters in 2003. Screening will be a part of the TIP.

Lessons from the immediate impact and first six months following the 9/11 WTC attacks were compiled by the New York Office of Alcoholism and Substance Abuse. Much of the data came from provider focus groups across a broad range of treatment and prevention programs, including school-based programs, throughout New York City, its suburbs and in selective upstate locations. Key themes from across groups include (New York Office of Alcoholism and Substance Abuse Services 2002):

- Substance abuse personnel need training in post-traumatic distress.
- Providers were particularly concerned about PTSD in previously traumatized clients who they assumed might relapse due to the retraumatization.
- Methadone providers should develop treatment protocols for clients who present as "guests" due to inaccessibility to their customary treatment program.
- There was increased use of tranquilizers and antianxiety medications post-event by 1) clients requesting prescriptions or testing positive for street drugs and 2) methadone patients requesting higher does prescriptions to deal with additional stress.
- Programs working with first responders and ground zero recovery workers reported concern with the heavy drinking that was a part of the camaraderie and rituals among that group post-event.
- Compared to October and November 2001, programs consistently reported increases in their December 2001census in readmissions, transfers and new admissions. Many clients presented with secondary stressors, subsequent to job loss or work-related problems, marital problems, criminal justice charges and health problems.
- Schools noted increased suspensions due to violence and bullying. Some providers attributed this to family distress including domestic violence and substance abuse, subsequent to economic loss.
- Several providers referenced treatment data out of Oklahoma City, citing increases in alcohol and other drug problems presenting more than five years after the 1995 bombing and so noting that for 9/11 survivors "the worst is yet to come."

G. First Responders The initial public safety teams to arrive at the site of an incident are known as first responders — traditionally, police, fire, rescue and emergency medical services (EMS). Their culture provides some protective factors against distress syndromes associated with disasters. As a group, first responders tend to deny and minimize the psychological consequences of their work and prefer to solve any problems internally (North et al 2002). Generally speaking this group experiences more psychological problems when children are victims of the event. Critical Incident Stress Management (CISM) and Critical Incident Stress Debriefing (CISD) have become embedded in the first responder culture as structured, group process for facilitating group understanding and assigning meaning to tragic events These services are generally guided by a specially trained team which includes a mental health professional and peer team. CISM services may be offered through the service's Employee Assistance Program (EAP) or through arrangements with local CISM-trained response teams. Concerns about confidentiality, perception of weakness and subsequently fitness for duty prevail across first responder groups and may serve as a barrier to responders' ability to access needed services.

The Debate Regarding CISM and CISD

SMHAs should be aware of the controversy surrounding Critical Incident Stress Management (CISM) and Critical Incident Stress Debriefing (CISD). Typically CISD is used within 48 hours of the event/shift to debrief and diffuse as people leave their roles. Research says people feel better but the long-term consequences are mixed: some do better, some remain neutral, some get worse. Sometimes people aren't comfortable with group process and complications could arise when groups are mixed with persons exposed to extreme situations and those that were not. Ideally, a menu of interventions (multi-component) across a range of time (phase-appropriate) should be offered to all impacted groups**,** with this one of the items for first responders. This should all be part of a mental health response system with mutual aid agreements in place to ensure coordination, efficiency and effectiveness of services. The workgroup agreed that research and best practices should be monitored and that CISD or CISM is best used with traditional first responders as originally designed and not for primary victims or other special populations.

First responders tend to seek and accept treatment later as was the case following the Oklahoma City bombing. When they did accept treatment, it was often because their supervisors, spouses, or companions applied pressure. Also, substance abuse issues in fire fighters are not new and appear to be part of their culture. The rate of current alcohol use disorder is 25% and the lifetime rate is nearly 50%.(North et al 2002) The "burden of heroism" brings another level of caution in managing the post-event recovery of first responders. When "just doing their job" causes them to be singled out as heroes and thrust into the limelight, they may experience greater distress. Special care should be taken over time to assure they have appropriate opportunities to normalize both their response and the public's attention.

H. Bioterrorism First Responders. In our changing world, bioterrorism first responders may come from any profession. No one ever expected U.S. Postal workers or members of Congress and their staff to be front line due to the anthrax mailings. However, health care providers (emergency room staff, clinic staff, primary care providers and behavioral health

care workers) are definitely a new front line for bioterrorism detection and response. Health care workers who feel thrust into this role without adequate training, assurance of safety and resource support, may feel role conflict. Managers must address demand scenarios and response capacity in a framework that considers: 1) Are health care responders adequately prepared for their new roles and can they assess risk given appropriate information and training? 2) Will personal concerns distract or even deter a key number of providers from filling critical care roles? 3) Do pre-surveys or individual/group discussions get employees to commit to serving during critical events, i.e., persons vaccinated for small pox? Helping workers to address their family needs so that they can be available to perform critical business functions is a key challenge for SMHAs. Such personal safety planning alleviates worker stress and enhances the potential that employees will come to/remain on the job Regarding role conflict, SMHAs should consider 1) People typically will perform their job responsibilities but it may be hard to get them to leave or disengage. 2) Once involved, the stimulus and stress may be incredibly overwhelming. 3) Do the same roles apply in a bioterrorist incident?

To alleviate worker stress and for general public safety, everyone is encouraged to have a family safety plan. Excellent guidance is available at www.ready.gov.

I. Domestic Violence. There is little *conclusive* evidence that domestic violence increases after major disasters, and as of this writing no published research on terrorism's impact. Yet research suggests that the postdisaster prevalence of domestic violence may be substantial. In the most relevant study, 14% of women experienced at least one act of postflood physical aggression and 25% reported postflood emotional abuse over a nine-month period. Another study reported a 46% increase in police reports of domestic violence after a disaster. Other studies show that substantial percentages of disaster victims experience marital stress, new conflicts, and troubled interpersonal relationships. There is more conclusive evidence that domestic violence harms women's abilities to recover from disasters. In the most relevant study, 39% of abused women developed postdisaster PTSD compared to 17% of nonabused women, and 57% of abused women developed postdisaster depression, compared to 28% of nonabused women. Marital stress and conflicts are highly predictive of postdisaster symptoms. In light of the fact that, in general, married women are a high-risk group for developing postdisaster psychological problems, SMHAs are advised to integrate violence-related screenings and services into programs for women, men and families.(Norris)

IV. ALL-HAZARDS PLANNING & RISK COMMUNICATIONS

A. All-Hazards Planning. All-Hazards Planning is a FEMA-based initiative where states develop an action plan that can be fine-tuned for response to any natural or human-caused disaster. NASMHPD developed the Mental Health All-Hazards Disaster Planning Guidance for SMHAs by reviewing state plans and defining best practices as well as developing a matrix of plan content. The SMHA's All-Hazards Plan details the agency's role and response in dealing with employees and service delivery to existing clients as well as the newer role of providing psychological first aid to the general public. SMHA All-Hazard Plans should be

Copies of the Mental Health All-Hazards Disaster Planning Guidance are available at www.nasmhpd.org and www.mentalhealth.org

organized and integrated according to the SEMA Emergency Operations Plan (EOP) which details the primary and secondary roles of each state agency

A big challenge for states is knowing what and how much to document. Therefore, a planning matrix is part of the All-Hazards Planning Guidance. SMHAs should realize that the planning matrix represents "the gold standard" of plans. Consider the plan a *program* with an eye toward maintenance, sustainability, testing, training and updating on an annual basis. Again, excellent guidance is available by accessing the publication on the two websites listed on page 18.

B. Risk Communications. Risk communication is the skillful practice of conveying information, opinions and possibly multiple messages regarding the risk/event to individuals, groups and institutions. People will turn to authority figures for information and public leaders need to answer questions and calm fears. Public officials including SMHA leaders should understand the power of media messages and ensure that all public communications are screened for the mental health impact.

Other risk communication preparedness efforts should focus on the following: 1) SMHA Public Affairs, the Governor's Office and the Public Health Agency should jointly craft targeted messages addressing such topics as the fear of potential exposure to a bioterrorist agent, the psychological impact of waiting for test results, etc. 2) SMHAs should develop fact sheets on the common physical and psychological reactions to specific agents such as SARIN, anthrax, small pox, etc. Specifically convey that the physiological impact of some biological exposure mimics stress reactions (i.e., agitation and cognitive impairment in SARIN exposure). 3) SMHA Public Affairs staff should review media messages crafted for the Governor, Public Health and other key agencies for the mental health impact of the information conveyed. 4) The SMHA Medical Director may serve as a resource to provide the public with information about direct and psychological impacts of the event.

> SAMHSA created a publication titled "Communicating in a Crisis: Risk Communications Guidelines for Public Officials." It is available online at www.mentalhealth.org or by calling SAMHSA's Mental Health Information Center at 1.800.789.2647 and referencing document number SMA 02-3641. SMHAs should obtain copies of the publication for key staff and conduct training on risk communication strategies and practices for disaster leaders.

Chapter Two

V. RECOMMENDATIONS

Throughout the workgroup summit and development of this document, the Council compiled numerous recommendations and lessons learned for improving SMHA terrorism response. The recommendations are organized according to the relevant disaster phases of pre-event preparedness, response phase and recovery. Table 3 illustrates the key disaster phases followed by the recommendations. Separate recommendations sections were developed for A) Medical Directors, focusing on clinical and service issues; B) SMHA Commissioners and Senior Staff, focusing on leadership and organizational concepts; and C) NASMHPD, focusing on resources, consultation and advocacy.

> Teach resilience throughout the preparedness stage of the disaster life cycle. Ensure appropriate programs and services throughout the disaster life cycle.

Table 3. Disaster Live Cycle

Pre-Event Preparedness	Preparedness ensures that if disaster occurs, individual citizens, volunteer groups, communities, businesses and governments are prepared to deal with the event safely and respond to it effectively. Each entity must prepare by developing a contingency plan in the event essential services break down, and practicing the plan on a regular basis with key partners. Developing good working relationships with disaster response organizations and sister agencies in advance of an event is essential.
Response Phase	Response begins as soon as a disaster is detected or threatens. It involves mobilizing and positioning emergency equipment; getting people out of danger; providing needed food, water, shelter and medical services; and bringing damaged services and systems back on line. Local responders, government agencies and private organizations take action. When the destruction goes beyond local and state capabilities, federal assistance is requested. The duration of the response phase varies according to the event. Traditional emergency responders want to move from response to recovery as quickly and safely as possible. Emergency responders work with political leaders to determine an appropriate transition timeframe and announcement. The response phase took several weeks in NYC as the WTC rubble was thoroughly sifted for survivors. Usually, when all efforts to find survivors have been exhausted, an operation moves into a recovery.
Recovery Phase	The task of rebuilding after a disaster can take months, even years. Not only services, infrastructure, facilities and operations, but also the lives and livelihoods of many thousands of people may be affected. Federal loans and grants can help. Funds are used to rebuild homes, businesses and public facilities, to clear debris and repair roads and bridges, and to restore water, sewer and other essential services. Research shows that psychological interventions may be needed from three to five years following the impact.

A. MEDICAL DIRECTORS: Clinical & Services Recommendations

1. Pre-EVENT PREPAREDNESS

a. Mental Health Outreach. There are several mental health response models and no "one size fits all" approach. A mental health response crafted from best practices appropriate to the impacted community is ideal. Review the Federal Emergency Management Agency (FEMA) Crisis Counseling Assistance and Training Program (CCP)[5] model which has been customized by SMHAs in Oklahoma City and in the 9/11 response (New York, Washington, D.C., Virginia, Connecticut and New Jersey). Also review crisis models practiced by the American Red Cross and the National Organization of Victim's Assistance and their best practices to tailor a program that works for the impacted community.

There is a need for training as the mental health community is not sending clear messages on the correct treatment and approaches to terrorism.

b. **Surge Capacity**. Prepare for surge capacity in hospitals, for morgue space in alternate sites such as warehouses, and transitional office space in other buildings such as vacant state hospitals.

c. **Substance Abuse**. SMHAs should develop strategies to support their current and more traditional population with co-occurring disorders while enhancing capacities to respond to substance abuse issues in the general population. Ensure monitoring of stress levels with consumers and train and cross-train with the substance abuse authority on terrorism and disaster issues.

d. **Stigma.** Mental Health professionals should address stigma as most terror events are not caused by the mentally ill.

e. **Medical Directors should remain visibly close to the Commissioner** during meetings and press conferences to add support and clinical credibility. Use Medical Director to provide public with information about direct and psychological impacts of the event.

f. Build relationships as detailed in Table 4.

[5] More information on the CCP appears on page 39 of this document as part of the resource listing for the Emergency Mental Health Services and Traumatic Stress Services Branch at the Center for Mental Health Services.

Table 4. SMHA Medical Director Relationships to Foster Pre-Event

Organization	SMHA Medical Director Action
Hospitals	Medical Directors should be available to advise and assist emergency rooms and crisis centers regarding a) mental health triage best practices, b) medication treatment of acute anxiety/agitation, c) evaluation of psychosomatic responses to biological/nuclear threats.
	The Medical Director can also do a grand rounds presentation at the local medical school on the psychological impact of terrorism.
Medical Societies and Professional Organizations	Commissioners and/or Medical Directors should link with the state medical society as well the individual specialty organizations such as psychiatrists, pediatricians, family physicians, internists, psychologists, social workers, school counselors, school nurses.
	Discuss and develop a volunteer list and a protocol to pre-screen, certify, train and deploy mental health volunteers.
	Review licensure and liability issues for both in-state and out-of-state mental health professions. As of this writing, the CDC is investigating the use of out-of-state providers to assist in the health response to bioterror events (i.e. small pox vaccinations.).
Private Benefit Plans and Employee Assistance Programs (EAP)	Offer the Medical Director's expertise to provide trainings to EAP staff on the psychological impact of terrorism.
Public/Academic Links	Work with academics to devise needs assessment and evaluation tools for SMHA programs as well as to design and seek funding for critically needed disaster research.

2. RESPONSE PHASE

a. **Medical Directors should remain visibly close to the Commissioner** during meetings and press conferences to add support and clinical credibility.

b. **Use mental health workers to assist in basic needs, medical services and outreach services.** Do not separate from but incorporate mental health with other services. Embrace the philosophy of "therapy by walking around."

c. **Conduct surveillance of state hospitals**. Assess and ensure adequate staff, medications, bed availability, etc.

d. **Review HIPAA implications** and legal guidance on medical records created or needed.

e. **Understand the National Pharmaceutical Stockpile (NPS) which is part of the Strategic National Stockpile (SNS)** Work with your State's Public Health Agency to ensure coordination of NPS medications to SMHA faculties and programs. To date, **no psychopharmacological drugs are kept in the NPS**. SMHA facilities traditionally maintain less than one week supply. Some states are investigating memorandums of understanding with pharmaceutical companies

as well as emergency procurement procedures to ensure access to psychotropic drugs. Devise methods to get meds to your patients, including methadone for those running substance abuse services. See the Glossary of Terms, attachment D, for more information on the NPS.

f. Be educated on drugs used to treat bioterrorism and how they mimic psychiatric issues. Refer to "Psychiatric Aspects of Biological Agents" on page 8 of this publication. Also, research shows that consumers deal fairly well with disasters and terrorism. *Stress* reactions in consumers can manifest in ways that mimic exacerbation of psychiatric illness (such as agitation, hyperarousal, sleep disturbance, etc.). Clinicians should evaluate whether anti-anxiety drugs are the only medication (if any) needed to address such symptoms during the initial stages of an event and avoid "medicalizing" such typical stress responses**.**

g. Do not overmedicalize transient normal reactions as most persons will not have long-term impairment. (Hoge et al 2002)

h. **Prioritize interventions.** Early interventions should be prioritized within a hierarchy of needs. Whenever possible interventions should be provided to groups of persons with prior and on-going social connections. The key components of early intervention follow (National Institute of Mental Health 2002):

1) Basic Needs
    a. Provide survival, safety and security
    b. Provide food and shelter
    c. Orient survivors to the availability of services/support
    d. Communicate with family, friends and community
    e. Assess the environment for ongoing threats
2) Psychological First Aid
    a. Protect survivors from further harm
    b. Reduce psychological arousal
    c. Mobilize support for those who are most distressed
    d. Keep families together and facilitate reunions with loved ones
    e. Provide information and foster communication and education
    f. Use effective risk communication techniques
3) Needs Assessment
    a. Assess the current status of individuals, groups, and/or populations and institutions/systems. Ask how well needs are being addressed, what the recovery environment offers, and what additional interventions are needed.
4) Rescue and Recovery Environment Observation
    a. Observe and listen to those most affected
    b. Monitor the environment for toxins and stressors
    c. Monitor past and ongoing threats
    d. Monitor service that are being provided
    e. Monitor media coverage and rumors

5) Outreach and Information Dissemination
    a. Offer information/education and "therapy by walking around"
    b. Use established community structures
    c. Distribute flyers
    d. Host web sites
    e. Conduct medial interviews and programs and distribute media releases

i. Emotional distress. Persons receiving medical treatment or who require no medical treatment may or may not be emotionally distressed. Nondistressed individuals may be discharged with education and reassurance. Distressed persons may need further intervention such as rest, reassurance, education and support. Place these people where disruptive behaviors can be monitored in a location removed from high-tempo triage activity but close enough to the main emergency room to allow access to further medical treatment, if required. Often, reassurance, support and rest are enough to diminish the emotional distress.(Lacy and Benedek 2003)

In addition, it is best to screen and triage in groups. Observe group members during information events as numbness and social withdrawal is more predictive of impairment than need for services from anxiety and insomnia. (Lacy and Benedek 2003)

j. Treating medically unexplained symptoms. When dealing with bioterrorism, WMD and outbreaks of medically unexplained physical symptoms (MUPS), lengthy incident scene investigations and elaborate searches for the offending agent may worsen and prolong the event. The group should be informed about the scope of the problem and the role of the offending agent should be minimized. Leaders should be calm, authoritative, supportive, and nonconfrontational. Individuals should be separated to minimize the spread of symptoms by sight and sound. Repetitive questioning about symptoms and use of language suggestive of infection or exposure should be avoided. The treatment of MUPS is more problematic. An empathetic, supportive, and collaborative stance combined with minimizing unnecessary medical tests and procedures is key. (Lacy and Benedek 2003)

> Reducing client anxiety in order to conduct the risk assessment was approximately 60% of the work in dealing with persons exposed to anthrax in New Jersey.

k. Treating anxiety and insomnia Benzodiazephines like lorazepam, clonazepam, or diazepam may be used for severe anxiety or insomnia. Patients treated with benzodiazepines should be cautioned about sedation and possible impairment in driving and decision-making. β-blockers such as propranolol and (ensure correct medical symbol for the next letter—see attached highlighted reference in Lacy article—I couldn't find the symbol in MSWORD) *x*-agonists such as clonidine may be useful for decreasing autonomic arousal as a result of their antiadrenergic

activity. Trazoden, zolpidem, or zaleplon are often the preferred choices for insomnia because they preserve sleep architecture. (Lacy and Benedek 2003)

l. **Group Debriefings**. Ensure that the group is composed of persons linked socially via working relationships or prior friendships rather than grouping merely by geographical proximity at the time of the scheduled debriefing. Reduce individual isolation and foster group cohesion with an open and frank discussion among care providers or persons concerned with the well being of participants. Focus on "what happened" by creating a cognitive historical narrative of the event. Participants should be allowed to express their feelings if they choose and those feelings should be supported. *Any attempt to extract the real or underlying emotions is strongly discouraged.* Those with prior abusive experience, minimal ability to regulate affect, limited ego-functioning, or serious preexisting mental illness may be harmed by being forced to participate in highly emotional, mandatory debriefings. (Lacy and Benedek 2003)

> Social efforts were often more productive than clinical efforts in terrorism response.

m. **Do not offer EMDR** or therapy consisting of detailed one-on-one recounting of events and emotions. (Dr. Parks to cite reference regarding EMDR from June 18-20 meeting)

n. **Exercise caution in TV watching**. Although people need accurate information, continuous, anxious speculation about the unknown or endless repeated images of violence are probably harmful and contribute to a sense of helplessness.

C. RECOVERY PHASE

a. **Recovery Interventions** Recovery interventions should be administered like early interventions in that there should be a prioritized hierarchy of needs and within community groups. (National Institute of Mental Health 2002)

1) Technical Assistance, Consultation and Training
    a Improve capacity of organizations and caregivers to provide what is needed to:
        i. Reestablish community structure
        ii. Foster family recovery and resilience
        iii. Safeguard the community
    b. Provide assistance, consultation, and training to relevant organizations, other caregivers and responders, and leaders
2) Fostering Resilience and Recovery
    a. Foster but do not force social interactions
    b. Provide coping skills training
    c. Provide education on stress responses, traumatic reminders, coping, normal vs. abnormal functioning, risk factors, and services
    d. Offer group and family interventions

e. Foster natural social supports
f. Look after the bereaved.
g. Repair the organization fabric

3) Triage
   a. Conduct clinical assessments, using valid and reliable methods
   b. Refer when indicated
   c. Identify vulnerable, high-risk individuals and groups
   d. Provide for emergency hospitalization
4) Treatment
   a. Reduce or ameliorate symptoms or improve functioning via
      i. Individual, family and group psychotherapy
      ii. Pharmacoptherapy
      iii. Short-or long-term hospitalization

b. Follow-up. Many survivors experience some symptoms in the immediate aftermath of a traumatic event. These symptoms are not necessarily cause for long-term follow-up because, in most cases, they will eventually remit. Survivors of traumatic events who do not manifest symptoms after approximately two months generally do not require follow-up. However, they should receive follow-up if they request it. The following individuals and groups are at high risk of developing adjusting difficulties post-event (National Institute of Mental Health 2002):

1) Persons who have ASD or other clinically significant symptoms stemming from the trauma;
2) Bereaved persons.
3) Individuals who require medical or surgical attention.
4) Those whose exposure to the event was particularly intense and of long duration.

c. Develop ways for people to be part of the recovery effort. Facilitate or support community group events to memorialize and heal. Organize self assistance to decrease sense of isolation and helplessness and rebuild social connections.

d. Promote resilience. Although everyone agrees that this is important, there are the questions of how to effectively promote resilience and what tools to use. The workshop experts discussed the importance of people having a recovery role following an event but what is that role? Specifically, develop guidelines on "what do we do 'if'?" Remind the community to go about their daily lives, keep their schedules, participate in their regular activities, etc.

B. SMHA COMMISSIONERS AND SENIOR STAFF: Leadership & Organizational Recommendations

1. Pre-EVENT PREPAREDNESS

a. **Build Relationships NOW**. Use this document for discussions with key agency and disaster leaders in your service area. Specifically make contact with the agencies in Table 5 to explain the psychological impacts of terrorism and the appropriate roles for SMHAs. Also, survey these organizations' expectations of Public Mental Health during critical events:

Table 5. SMHA Relationships to Foster Pre-Event

Organization	SMHA Action
State Emergency Management Agency (SEMA)	Invite a SEMA representative to brief SMHA leadership on Incident Command System or check in with www.fema.gov for an on-line tutorial.
	Participate and offer mental health expertise for SEMA trainings and exercises.
Public Health	Ensure mental health is involved in their surveillance efforts
	Explain the mental health impact of terrorism to their director and ensure that their crisis and risk communication strategies address the mental health impact of their information and messages
	Check out www.cdc.gov and www.bt.cd.gov for additional general public health information as well as content specific to bioterrorism.
	Educate Public Health on the up-to-date roles of SMHA state hospitals as often assumptions are made based on history.
	Discuss the reality of bed-availability, medical stockpiles, etc. SMHAs should work with their Public Health leaders to coordinate services and obtain funds for behavioral health preparedness.
	Offer to assist Public Health in dealing with the anxiety of persons they contact during data collection and surveillance efforts who are at risk.
	Consider inserting Mental Health terror issues via the licensing function.
	Work with Public Health on a quarantine plan.
	Promote pre-event coordination among SMHAs, Public Health and Substance Abuse authority to clarify roles, risk messages and areas for collaboration as well as patterns for referral.
State Homeland Security	Talk to them on the mental health impact of terror. How are they linked with SEMA? What is the chain of command and integration among the two agencies?
American Red Cross (ARC), Salvation Army, National Voluntary Agencies Active in Disaster (NVOAD)	Salvation Army and the NVOAD should have a representative/liaison to SEMA. Ensure you know that person and how your SMHA can collaborate with these groups.
Substance Abuse and Mental Retardation/Developmental Disabilities	If your SMHA does not coordinate these services, be sure to partner with the state agency which does.
	Work with FEMA and CMHS to provide customized brochures and have substance abuse information available in advance.
Domestic Violence Agencies	Include them in emergency planning, meetings and trainings.
Advocacy Groups such as National Alliance for the Mentally Ill (NAMI) and National Mental Health Association (NMHA)	Involve these groups in planning and programming.
	Work with the advocacy community to incorporate disaster and substance abuse issues into their meetings.
	NMHA has excellent disaster and terrorism fact sheets available on their website at www.nmha.org
Medical Societies and Professional Organizations	Commissioners and/or Medical Directors should link with the state medical society as well the individual specialty organizations such as psychiatrists, pediatricians, family physicians, internists, psychologists, social workers, school counselors, school nurses, etc.

Organization	SMHA Action
	Discuss and develop a volunteer list and a protocol to pre-screen, certify, train and deploy volunteers.
	Review licensure and liability issues for both in-state and out-of-state mental health professions. As of this writing, the CDC is investigating the use of out-of-state providers.
Education	Commissioners should contact the State Commissioner of Education and encourage linkage among community mental health centers and local school districts.
	SMHAs may want to link their websites with those containing information on working with children during disasters/terrorism. Youth crisis hotline numbers should be promoted.
	SMHAs can offer in-service trainings to teachers on stress management and provide "fact sheets for families" on typical psychological responses to be sent home with students.
First Responders	Develop personal relationships with first responders assigned to jurisdictions with SMHA facilities and office buildings.
	Provide them with information on the psychological impact of terrorism and explain the SMHA role and resources.
	Be trained in the Incident Command System.
	Partner with these groups on training and exercises as appropriate.
State Attorney General's (AG) Office	The SMHA should work with the State Attorney General's Office to understand what role mental health should play in the state and how to coordinate with the services of National Organization of Victims' Assistance (NOVA) if they are called in to assist with the psychological impact of an event that is also a crime.
Hospitals	Medical Directors should be available to advise and assist emergency rooms and crisis centers regarding a) mental health triage best practices, b) medication treatment of acute anxiety/agitation, c) evaluation of psychosomatic responses to biological/nuclear threats
	The Medical Director can also do a grand rounds presentation at the local medical school on the psychological impact of terrorism
Private Benefit Plans and Employee Assistance Programs (EAP)	Offer your medical director's expertise to provide trainings to EAP staff on the psychological impact of terrorism
Public/Academic Links	Work with academics to devise needs assessment and evaluation tools for your programs as well as to design and seek funding for critically needed disaster research.
Agriculture Department	Know that Agriculture will be frontline for bioterrorism attacks on livestock and crops.
	Use Extension Services to obtain needs assessment information and/or to deliver public education to rural communities and groups
Faith Community	SMHA should include these groups to educate and train on topics such as disaster metal health, stress-management, substance abuse as well as vicarious traumatization and compassion fatigue. Procedures for referral for more formalized mental health services should also be covered.
	Explore the capabilities of Interfaith groups to assist with the unmet needs of victims/survivors.
Miscellaneous Community Organizations and Not-For-Profits	Train leaders at existing youth organizations on how to talk with children in age appropriate ways and how to identify children who may need additional support due to increased stress in the home.

b **Understand and, when possible, enhance the State Mental Health Authority's disaster and terrorism response infrastructure**.

- **Ensure that the State Mental Health Authority is on the call-down list for disaster/critical event notification by the Governor's Office and the State Emergency Management Agency**. Also ensure that you have the names and numbers of contact people at the various agencies in case you need to report an event or situation under your jurisdiction.

> Be prepared for impacted communications systems, resulting in a temporary loss of cell phones, pagers, internet access etc.

- **Know the Emergency/Disaster Coordinator in your agency**. Each SMHA should have an assigned, internal disaster coordinator. Few states (i.e., Texas, California) have a full-time employee while others have personnel assigned this responsibility as a percentage of their time.
- **Ensure the Emergency/Disaster Coordinator has access to the Mental Health Commissioner, is a trusted representative of the agency's director and senior management, and has the right leadership traits for the position**. The person should be creative, flexible, able to function in chaos under stressful conditions and often with ambiguous direction, a good delegator and communicator, diplomatic and confidant, and familiar with the application process for the FEMA Crisis Counseling Program. Ideally this person has attended the CCP training held at FEMA's national training campus in Emmitsburg, MD, is media savvy, and an excellent networker and negotiator.
- **Build internal and external relationships.**
  Internally. Develop a disaster/crisis team and delineate responsibilities. Most SMHAs have a disaster coordinator who will have lead responsibility for grant applications and program management. Also include public affairs staff, general counsel, medical director plus representatives from psychiatric services, substance abuse and MRDD, if your agency provides such services.
  *Externally***.** It is too late to develop relationships during the event. SMHAS can't reach out early and often enough to develop collaborative partnerships. Check egos at the door and work closely with SAMHSA and FEMA. The State should assist the impacted locality and not dictate. The same is true of the Federal relationship to the State. Generally speaking, the Commissioner fosters relationships at the agency director level and is the direct link to the Governor/Mayor. The disaster coordinator works with frontline disaster response agency representatives and other groups involved in disaster mental health outreach, education programs and services. The medical director is lead in working with health and medical representatives. Other agency representatives may be assigned a lead responsibility such as General Counsel or Chief of Staff. Carefully match SMHA representatives with expected responsibilities and personal work style. See Table 5 on page 27 for the list of groups with which to partner.

> During an event, mental health staff should be assigned immediately to the Mayor's and/or Governor's Office.

- **Commit to all-hazards planning.** See page 18.

- **Understand Mental Health's responsibility as outlined by the State Emergency Management Agency(SEMA) emergency operations plan (EOP) as well as detailed in your agency's All-Hazards Plan**. The SEMA EOP details the primary and secondary roles of each state agency. In addition to mental health's responsibilities in that document, there will also be a plan at the SMHA detailing the agencies role and response in dealing with employees and service delivery to existing clients as well as the newer role of public psychological first aid. The SMHA Disaster Coordinator should be able to brief the Commissioner and Medical Director on these roles and responsibilities. These two documents should be integrated and consistently exercised and updated.
- **Be sure all services and special populations have been considered in the SMHA's All-Hazard Plan**. Not all SMHAs coordinate addiction services, forensic services or services for citizens with mental retardation/development disabilities. Be sure that these services have been addressed and coordination agreed upon with the sister agency during the preparedness stage. In addition, ensure services and fact sheets are readily available to deal with issues specific to children and adolescents; the elderly; immigrant, refugee and migrant populations; hearing and/or visually impaired, racial/ethnic minorities, consumers and other groups as identified.
- **Understand Risk Communications**. See tips on page 19.
- **Know what support services may be available through NASMHPD**. The commissioners and medical directors who responded to 9/11, Oklahoma City, Columbine High School shootings and a host of other critical events may be available to discuss lessons learned and provide insights into dealing with the situation in your state. Also, during the early stages of 9/11, NASMHPD screened all volunteer offers for the NY State Office of Mental Health. Contact NASMHPD at 703.739.9333 determine what role they may play for your agency during critical times.

c. **Develop mutual aid agreements** within the state/jurisdictions and with neighboring states/jurisdictions to provide consistency and continuity of services.

> Donated goods management is a huge issue. Check with SEMA regarding expertise in your state to handle this.

d. **Understand your State procurement system and make provisions for acquiring materials and services during critical events**. Pre-identify situations and procurement requirements. Can you buy what you need or accept donations directly? One state worked with their Emergency Management Agency on an emergency procurement plan where $1 million in credit is available to support all state agencies with a pre-identified list of potential needs for each agency on record with the SEMA. In response to 9/11, one state found it difficult to accept $1 million in emergency funds from the President as there was no mechanism to do so. Eventually, they used a private foundation to accept and administer these funds.

e. **Conduct regular resource review.** Link with the Disaster Technical Assistance Center (DTAC) for regular review of disaster literature and information on grants and workshops which may be funded through SAMHSA, FEMA, DOJ, CDC, etc. Contact DTAC, 7735 Old Georgetown Road, Suite 400, Bethesda, MD 20814, 800.308.3515 DTAC@esi-dc.org

f. Conduct and participate in exercises to test all hazard plans in response to WMD, bioterrorism and terrorism scenarios. Participate in local/state exercises and training opportunities with SEMA, Public Health, Education, American Red Cross, and other groups as identified above. Ensure that SMHA hospitals, community mental health centers and MH administration participate. Such preparedness efforts and clarification of roles pre-event allow for a more effective psychology response during an actual event.

2. RESPONSE PHASE

a. **Get your agency involved in external/internal consultation & assessment. Begin by determining if a formal mental health response is appropriate at this time.** Is it time to activate and deploy crisis response teams or other specialized groups? Is the SMHA providing expected and appropriate services to the impacted groups and regions? Is SMHA supporting disaster leaders (Gov., Mayor, SEMA, etc.) as anticipated/expected and have mental health staff been assigned to those offices? How are SMHA employees faring? Has the daily mission of the organization been impacted? Are SMHA leadership communications to staff clear and do they provide the information needed by the workforce?

> Emergency response leaders and managers may experience "guilty relief." Because of access to inside information and overload of detail, be aware of a tendency to become insensitive, i.e. being relieved at 1,000 deaths instead of an anticipated 5,000.

b. **Work with SEMA and the Governor's Office to determine if the State will apply for a Presidential Disaster Declaration.** Funding for a FEMA crisis counseling program should be considered when going forward for a Presidential disaster declaration. Understand the parameters of the program.

c. **Keep records of all resources expended so you can be reimbursed as well as prove that you spent and obligated funds appropriately**. Start tracking your expenditures from the day you begin consultation and assessment as you may be reimbursed for these costs. Remember that FEMA provides clear guidelines on how the CCP funds may be used. Be aware that Federal auditors may review your program and this possibility increases the larger the funding amount and the higher the media attention.

d. **Work with your disaster coordinator and check in on the response priorities outlined in your agency's all-hazards plan**. Be sure to link with the Emergency

Management Agency and provide staff as agreed to at the Emergency Operations Center and other locations.

e. **Cross-utilize staff from other agencies when possible.** i.e., nurses and other health professionals from Public Health, social workers from Department of Social Services.

f. **Contact NASMHPD for support services which may be available at 703.739.9333** Develop more materials to help citizens recover, be stronger and promote resilience.

g. **Be high profile, calm and caring**. Be out and be seen in your organization to offer support and instill confidence in your employees. Work closely with the Governor's Office and State Emergency Management Agency.

h. **Inform other professional organizations/medical agencies/clinical groups/other state agencies on SMHA role and ongoing assessment**.

i. **Work with the Public Affairs staff on the public information and education messages** you want to provide such as the consequences of specific bioterrorist agents, what to do for children, etc. Provide flyers and websites links.

j. **Anticipate the following**:
   1) **Unrequested volunteers**. They will begin calling the office and arriving on the scene almost immediately. Assign someone to deal with them and take names and numbers. Ideally you will have pre-screened, trained and have a cadre of local volunteer professionals available.
   2) **People want something to do**. Have a list of small but meaningful tasks for employees/volunteers.
   3) **FEMA, CHMS, Red Cross, Salvation Army and other "sanctioned" disaster organizations will show up soon.**
   4) **Overdedication of management and staff**. Devise shift limits and promote stress management and physical well-being. Most people pull together and function following an event but their effectiveness is diminished. Rest is critical to prevent burnout.
   5) **Flexibility & creativity in response**. When TWA Flight 800 crashed outside of New York City in 1999, the recreation therapists had the most sought-after skills among the many mental health staff available. Families had come from across the US and overseas to wait for word regarding what caused the event. Be prepared to be flexible and creative to meet the needs of those impacted by the event.

3. RECOVERY

a**. Be sure to obtain and organize funding, resources, staff and planning for the long-term.** Current research shows that the psychological impact may continue for 3-5 years. One-third of those directly impacted will have ongoing PTSD and/or depression and 10% of persons in the vicinity of the event will have ongoing PTSD and/or depression. Think long-term to ensure

> The response after the event is just as important as during the event.

adequate services and staffing.

b. **Ensure that the Mental Health Commissioner or trusted representative is sitting at table when charitable contributions are dispersed**. Funding for long-term mental health care may be needed and usually donations are the only source for treatment. In Oklahoma City, the Red Cross continued to pay for mental health services for persons during 2002, more than seven years post-event.

c. **Advocate for an increase in community Mental Health capacity**

d. **Understand the impact of anniversary dates**. Research shows that mental health and substance abuse issues surge around the six-month and annual anniversary dates of the event. Other triggers include memorial events, trials, etc.

e. **Medical Directors should remain visibly close to the Commissioner** during meetings and press conferences to add support and clinical credibility.

C. RECOMMENDATIONS TO NASMHPD

a. **Develop guidelines on how to credential, pre-screen and train volunteer mental health professionals who offer their services during critical times**. There is a clear need for a National Credentialing System. Advise on liability and licensure issues as well, particularly for professionals who are from out-of-state.

b. **Screen and compile the best public information handouts on terrorism**. Work with the Disaster Mental Health Technical Assistance Center, if appropriate.

c. **Facilitate member-to-member technical consultation**. Several commissioners remain involved with the 9/11 response. Their lessons learned and best practices are essential to those dealing with terrorism issues. Other examples of recommended information sharing include state-to-state expertise of NASMHPD's other groups including the children's division, legal division (including licensing, HIPAA, liability, scope of practice), procurement issues ($1 million from President to NY State through Research Foundation), forensic (evacuation issues), etc.

d. **Advocate for**:
   1) **Integration of Federal Efforts**. Several agencies are involved in terrorism response including Homeland Security (which now houses FEMA), SAMHSA, HRSA, CDC, to name a few. All training, consultation and education to the states should be coordinated to ensure streamlined services and effectiveness of Federal dollars. Encourage a system where State Departments *collaborate* on programs with their Federal and State partners and not *compete* for program funding.
   2) **Behavioral health measures and surveillance**. Public Health is at the forefront of terrorism response and it is critical that they include behavioral health measures in

their surveillance efforts. Work with the Public Health national associations and government entities to make this happen.

3) **Longer-term funding for disaster mental health services**. Research and experience show that the psychological impact of terrorist acts is much greater, with some victims requiring services 3-5 years past the event. The FEMA model provides funding for short-term crisis counseling services. Treatment funds adjunct to the FEMA funds could be explored through Health and Human Services and other Federal agencies as identified.
4) **Research funds**. Research regarding the mental health impact of disasters and terrorism is greatly needed. It took more than 20 years for FEMA to approve funds for program evaluation. The workgroup suggests that the best source for disaster/terrorism mental health research may be through the National Institute of Mental Health.
5) **Preparedness funds**. After 9/11, preparedness efforts in mental health response are even more warranted but there is no long-term funding. Explore with FEMA the possibility of preparedness funding and review the Texas Department of Mental Health's partnership with their EMA to leverage funding for preparedness, staff and other disaster related needs.

Chapter Three

VI. KEY AGENCIES AND BEHAVIORAL HEALTH PROGRAMS IN TERRORISM RESPONSE

It is imperative that SMHAs become familiar with the Federal and State agencies and national organizations involved in terrorism response. Pre-existing relationships are essential during times of crisis and even more so when responding to terrorist events. Information regarding these terrorism and disaster response agencies, their roles and programs is provided in Chapter Three. This chapter begins with an overview of the Federal Department of Homeland Security and highlights partner organizations with a behavioral health component. Specifics on how to link and partner with these organizations are addressed in Table 5 on page **27**.

A. Department of Homeland Security http://www.dhs.gov/dhspublic/index.jsp

In the aftermath of the September 11th, 2001, terrorist attacks, the Federal government coordinated 22 previously disparate domestic agencies into one department to protect the nation against threats to the homeland. The creation of the Department of Homeland Security (DHS), effective March 1, 2003, is the most significant transformation of the U.S. government since 1947, when Harry S. Truman merged the various branches of the U.S. Armed Forces into the Department of Defense to better coordinate the nation's defense against military threats. Besides providing a better-coordinated defense of the homeland, DHS is also dedicated to protecting the rights of American citizens and enhancing public services, such as natural disaster assistance and citizenship services, by dedicating offices to these important missions. The agencies guided by the Department of Homeland Security are housed in one of four major directorates as listed in Table 6.

Table 6. Department of Homeland Security Organization

Directorate	Focus	Agencies
Border and Transportation Security	To coordinate major border security and transportation operations	The U.S. Customs Service (Treasury) The Immigration and Naturalization Service (part) (Justice) The Federal Protective Service (GSA) The Transportation Security Administration (Transportation) Federal Law Enforcement Training Center (Treasury) Animal and Plant Health Inspection Service (part)(Agriculture) Office for Domestic Preparedness (Justice)
Emergency Preparedness and Response	To oversee domestic disaster preparedness training and coordination of government disaster response	The Federal Emergency Management Agency (FEMA) Strategic National Stockpile and the National Disaster Medical System (HHS) Nuclear Incident Response Team (Energy) Domestic Emergency Support Teams (Justice)

Directorate	Focus	Agencies
		National Domestic Preparedness Office (FBI)
Science and Technology	To utilize all scientific and technological advantages when securing the homeland.	CBRN Countermeasures Programs (Energy) Environmental Measurements Laboratory (Energy) National BW Defense Analysis Center (Defense) Plum Island Animal Disease Center (Agriculture)
Information Analysis and Infrastructure Protection	To analyze intelligence and information from other agencies (including the CIA, FBI, DIA and NSA) involving threats to homeland. security and evaluate vulnerabilities in the nation's infrastructure	Critical Infrastructure Assurance Office (Commerce) Federal Computer Incident Response Center (GSA) National Communications System (Defense) National Infrastructure Protection Center (FBI) Energy Security and Assurance Program (Energy)

Other DHS agencies include the Secret Service and the Coast Guard which report directly to the Secretary. In addition, the INS adjudications and benefits programs report directly to the Deputy Secretary as the Bureau of Citizenship and Immigration Services.

To find the homeland security leaders in each state, access http://www.whitehouse.gov/homeland/states/ne.html

B. **Federal Emergency Management Agency (FEMA)** www.fema.gov

FEMA is now housed in the Department of Homeland Security. More than 2,600 full time employees are based at FEMA headquarters in Washington D.C., at regional and area offices across the country, at the Mount Weather Emergency Operations Center, and at the FEMA training center in Emmitsburg, Maryland. FEMA also has nearly 4,000 standby disaster assistance employees who are available to help out after disasters. With responsibilities ranging from advising on building codes and flood plain management to coordinating the federal response to a disaster, FEMA's role is tied to the **life cycle of disasters**. The disaster life cycle describes the following process for emergency managers:

- **prepare** for emergencies and disasters
- **respond** to them when they occur
- help people and institutions **recover** from them
- **mitigate** their effects
- **reduce the risk** of loss, and
- **prevent** disasters such as fires from occurring.

Often FEMA works in partnership with other organizations that are part of the nation's emergency management system. These partners include state and local emergency management agencies, 27 Federal agencies and American Red Cross.

Local and State governments share the responsibility for protecting their citizens from disasters, and for helping them to recover when a disaster strikes. In some cases, a disaster is beyond the capacity of the State and local government to respond. The Robert T. Stafford ***Disaster Relief and Emergency Assistance Act***, Public Law 93-288, as amended (the Stafford Act) was enacted to support State and local governments and their citizens from overwhelming disasters. This law establishes a process for requesting and obtaining a Presidential Disaster Declaration, defines the type and scope of assistance available under the Stafford Act, and sets the conditions for obtaining that assistance. A detailed explanation of the disaster declaration process is found in the Glossary of Terms, Attachment D.

SMHAs should understand the disaster response leadership structure and terminology. Get trained in the Incident Command System. Review FEMA and SEMA acronyms and vocabulary.

Federal disaster assistance available under a major disaster declaration falls into three general categories. However, not all programs are activated for every disaster:

- **Individual Assistance (IA)**—aid to individuals, families and business owners. The Crisis Counseling Program is provided through IA.
- **Public Assistance (PA)**—aid to public (and certain private non-profit) entities for certain emergency services and the repair or replacement of disaster-damaged public facilities;
- **Hazard Mitigation Services**—funding for measures designed to reduce future losses to public and private property. In the event of a major disaster declaration, all counties within the declared State are eligible to apply for assistance under the Hazard Mitigation Grant Program.

Some declarations will provide only individual assistance or only public assistance. Hazard mitigation opportunities are assessed in most situations. The Crisis Counseling Training and Assistance Program (CCP) is available through individual assistance. See Emergency Services and Disaster Relief Branch below for more details.

C. State Emergency Management Agency (SEMA)

Every state has an agency linked to FEMA to coordinate disaster response at the state and local level. Every State Emergency Management Agency has an overall Emergency Operations Plan (EOP) detailing the primary and secondary roles of each state agency. The FEMA website also lists the SEMA office and contact information in each state.

D. The Centers for Disease Control and Prevention (CDC)) www.cdc.gov

A new mission for CDC is to strengthen local, state, and national public health capacity to respond to growing threats from biological and chemical terrorism. Traditionally, CDC is recognized as the lead Federal agency for protecting the health and safety of people (at home and abroad), providing credible information to enhance health decisions, and promoting health through strong partnerships. CDC serves as the national focus for developing and applying disease prevention and control, environmental health, and health promotion and education activities designed to improve the health of the people of the United States. CDC, located in Atlanta is an agency of the Department of Health and Human Services.

E. State Public Health

The science and art of preventing disease, prolonging life and promoting health and efficiency through organized community effort. Winslow, 1920

Fulfilling society's interest in assuring conditions in which people can be healthy. Institute of Medicine Report, 1988

A collective effort to identify and address the unacceptable realities that result in preventable and avoidable health outcomes, and it is the composite of efforts and activities that are carried out by people committed to these ends. Turnock, 1997

The definition of Public Health has changed over the years. Historically, Public Health's primary roles have been to 1) collect data and conduct surveillance rather than provide treatment to the general population, and 2) reduce risk factors using campaigns targeting diseases such as sexually transmitted diseases (STDs) and tuberculosis. The health of the entire population is addressed, focusing more on the individual and seldom on the full family. In general, these individuals may be seen as conditions and defined as diabetics, HIV patients, etc. Just as with SMHAs, there is tremendous variability in the Public Health state systems.

Today Public Health is perceived as the leader in bioterrorism response with funding for their programs at an all-time high while the remainder of their department budgets decline. Federal funding sources for Public Health bioterrorist programs include Agriculture, Education, Health and Human Services, SAMHSA, Centers for Disease Control, private foundations, etc. Rarely do these funds or programs consider or address the behavioral health consequences of terrorism. Fortunately, this is changing due to proactive SMHAs who team with their Public Health colleagues on terrorism response. Clearly, cross-training of and collaboration between Public Health and Mental Health employees makes sense. There is a deep personnel pool of Public Health nurses and educators as well as certified counselors to potentially assist with public education and counseling during critical events. SMHA staff can assist with data collection and surveillance as well as ensure Public Health programs and messages are reviewed to address their mental health impact.

F. Strategic National Stockpile (SNS) Beginning March 1, 2003 the Department of Homeland Security (DHS) oversees the Strategic National Stockpile. As part of the SNS, the Centers for Disease control continues to administer the **National Pharmaceutical Stockpile (NPS) Program** http://www.bt.cdc.gov/stockpile/. The NPS mission is to ensure the availability of life-saving pharmaceuticals, antidotes and other medical supplies and equipment necessary to counter the effects of nerve agents, biological pathogens and chemical agents. The NPS Program stands ready for immediate deployment to any U.S. location in the event of a terrorist attack using a biological, toxin or chemical agent directed against a civilian population. The NPS is comprised of pharmaceuticals, vaccines, medical supplies, and medical equipment that exist to augment depleted state and local re-sources for responding to terrorist attacks and other emergencies. These packages are stored in strategic locations around the U.S. to ensure rapid delivery anywhere in the country. **Psychotropic medications are NOT a part of the NPS.** For more details, see the Glossary of Terms, Attachment D or visit www.bt.cdc.gov for specific information on NPS and CDC's role in terrorism response.

G. Emergency Mental Health and Traumatic Stress Services Branch (EMHTSSB) in the Center for Mental Health Services (CMHS) at the Substance Abuse Mental Health Services Administration (SAMHSA). www.mentalhealth.org

Currently**,** SAMHSA is the key Federal partner for the psychological response to Presidentially declared disasters and crisis counseling programs in response to terrorism. The EMHTSSB is funded through an interagency agreement with FEMA and CMHS to ensure that victims of Presidentially declared disasters receive immediate, short-term crisis counseling, as well as ongoing support for emotional recovery. CMHS collaborates with FEMA to train State mental health staff to develop crisis counseling training and preparedness efforts in their States. The EMHTSSB historically responds to natural disasters but has also been involved with Oklahoma City and 9/11 programs as these events received the Presidential Disaster Declaration.

EMHTSSB coordinates the **Crisis Counseling Assistance and Training Program (CCP),** authorized by §416 of the Stafford Act. The CCP is designed to provide supplemental funding to States for short-term crisis counseling services to people affected by Presidentially declared disasters. There are two separate portions of the CCP which can be funded: immediate services and regular program. A State may request either or both types of funding. The **immediate services program** is intended to enable the State or local agency to respond to the immediate mental health needs of disaster victims with screening, diagnostic, and counseling techniques, as well as outreach services such as public information and community networking. The **regular program** is designed to provide up to nine months of crisis counseling, community outreach, and consultation and education services to people affected by a Presidentially declared disaster. Funding for this program is separate from the immediate services grant. To be eligible for crisis counseling services funded by this program, the person must be a resident of the designated area or must have been located in the area at the time the disaster occurred. The person must also have a mental health problem that was caused by or aggravated by the disaster or its aftermath, or he or she must benefit from services provided by the program. **For more information contact: EMHTSSB/CMHS/SAMHSA, 5600 Fishers Lane, Parklawn Building , Room 17C-20, Rockville, MD, 20857, 301.443.4735 (p) 301.443.8040 (f)** www.mentalhealth.org

> When designing and delivering mental health services for the impacted area, know the community social context. Specifically, identify socially isolated and alienated groups, issues of family instability and conflict, literacy levels, and damage to social supports.

SAMHSA also has funding opportunities known as Emergency Regulations Grants. These funds come from a 2 1/2% reserve of the overall SAMHSA budget and may be used for events that exceed the state capacity but do not qualify as a Presidential Disaster. For example, Rhode Island received funding for services following a nightclub fire in 2003 where 100 died and 167 were injured. These funds are broad based and may be used for treatment, hospitalization, medications and case management. For more information, contact the Emergency Management Coordinator, Office of Policy, Planning and Budget, SAMHSA, 5600 Fishers Lane, Parklawn Building, RM 12C-05, Rockville, MD 20857 301.443.6213 301.443.7590 (f)

EMHTSSB presently funds a Disaster Mental Health Technical Assistance Center (DTAC) for the states which can provide materials development, meeting support and other technical assistance. Contact DTAC, 7735 Old Georgetown Road, Suite 400, Bethesda, MD 20814,

800.308.3515 DTAC@esi-dc.org (Note 8/14/03 to NASMHPD: They are in the process of establishing a website which should be up and running in September. Please call for URL)

H. National Child Traumatic Stress Network (NCTSN) www.NCTSNet.org
In October 2001, SAMHSA, established the NCTSN to improve the mental health and well being of children and families who have experienced traumatic events. The NCTSN is composed of 36 Centers across the country and led by the National Center for Child Traumatic Stress (NCCTS), which is co-located at the University of California—Los Angeles (UCLA) and Duke University Medical Schools. The Terrorism and Disaster Branch of the National Center is dedicated to enhancing the national capacity to plan and respond to terrorism and disaster on behalf of the mental health of youth and their families. Incorporating the extensive experience and expertise from across the Network, the Terrorism and Disaster Branch has launched a Rapid Response Support Team (RRST) capable of providing consultation before or after diverse types of mass casualty events. Services include:

- Consultation with federal, state, and local agencies regarding child and family mental health issues in preparedness, mitigation, response, and recovery for mass casualty events
- In-house staff with worldwide expertise in addressing terrorism and disaster
- Reach back to more than 100 professionals trained in traumatic stress studies and the 36-Center Network resources across the United States
- Single point of contact for access/response coordination, 24hrs/7days at (800) 759-2380 (24 hours)

I. American Red Cross (ARC) www.redcross.org
In 1905 the Red Cross was chartered by Congress not as a government agency but as disaster relief organization. Through its network of chapters, service delivery units and national headquarter operations, the ARC provides disaster relief services to people affected by disasters 24 hours a day, 365 days of the year. Red Cross disaster relief services are free and focus on meeting people's **immediate** emergency disaster-caused needs. Two of the most visible and well-known of Red Cross disaster relief activities are sheltering and feeding. Other services include health and first-aid, provision of blood and blood products, and assisting out-of-area relatives in determining the well-being of their family member. The Red Cross responds to natural disasters, airline accidents and terrorist events.

ARC Disaster Mental Health Services workers are licensed mental health practitioners trained to recognize the disaster's emotional impact on victims/survivors as well as disaster workers. They offer information and help educate people on the emotional impacts of disasters and how to cope with them. ARC is committed to short-term assistance only. It is imperative that the SMHA coordinate with them so that when ARC leaves, the community recognizes that ongoing mental health resources are available. Be aware that ARC authority emphasizes local control. The power of the local and state lead chapter and their relationship with the National ARC office varies across the country. Some SMHAs have developed memoranda of understanding (MOUs) with the local chapter that have not been sanctioned by National Red Cross and vice versa.

J. National Voluntary Organizations Active in Disaster (VOAD) www.nvoad.org
On July 15, 1970 representatives of seven voluntary organizations signaled their desire to work together in time of disaster by forming the National Voluntary Organizations Active in Disaster

(NVOAD). NVOAD coordinates planning efforts by many voluntary organizations responding to disaster. Member organizations provide more effective and less duplication in service by getting together before disasters strike. Once disasters occur, NVOAD or an affiliated state VOAD encourages members and other voluntary agencies to convene on site. This cooperative effort has proven to be the most effective way for a wide variety of volunteers and organizations to work together in a crisis. NOVAD has more than 35 national partners including the Salvation Army, the American Red Cross and other not-for-profit and/or faith-based groups such as Catholic Charities, Mennonite Disaster Services and World Church Services, to name a few. These groups do an exceptional job of identifying unmet needs among disaster victims and maximizing available resources for such needs.

K. State Attorney General's (AG) Office.

There is often a state victims' assistance and compensation group affiliated with the State Attorney General's Office which receives funding through the Department of Justice (DOJ) Office of Victims of Crime (OVC). The Anti-Terrorism Act, enacted after the bombing of the Murrah Building in Oklahoma City, allows the OVC to use federal funds to serve victims of terrorism and mass violence. Often the National Organization of Victims Assistance (NOVA) is requested (by the AGs Office or other entity) to provide counseling services following events that are also a crime scene. NOVA relies heavily on the services of local volunteers (of whom most have completed a 40-hour crisis counseling course), and a national volunteer corps of practitioners from fields as diverse as criminal justice, social services, the military, clergy, medicine, and mental health. In addition to those practitioners, who perform training and technical assistance on a wide array of victim-related topics, NOVA's National Crisis Response Team database houses in excess of 2,000 volunteer crisis responders. NOVA is committed to the continued involvement of volunteers from the community who are concerned about crime victims. Often their services are funded throughout the legal proceedings.

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